ATTACHMENT 5 Sample CMS 1500 claim form for vision services

PICA				HEALTH IN	SURANU		-MIIVI	FUF	١W		P	ICA]]
. MEDICARE MEDICA!	CHAMPUS	CHAMPVA	GROUP HEALTH PLAN	FECA OTHER BLK LUNG	R 1a. INSURED	'S I.D. NU	JMBER			(FOR F	PROGRAM II	VITEM 1)
(Medicare #) $\widehat{\mathbf{P}}$ (Medicaid	#) (Sponsor's SSN	V) (VA File	#) (SSN or ID)	(SSN) (ID)	12345	56789	0					
PATIENT'S NAME (Last Name	, First Name, Middle Initi	ial)	3. PATIENT'S BIRTH DATE	SEX	4. INSURED'S	NAME (Last Nan	ne, First I	Name	, Middle	Initial)	
Recipient, Im A.			MM DD YY	M FX								
. PATIENT'S ADDRESS (No., S	treet)		6. PATIENT RELATIONSHI	IP TO INSURED	7. INSURED'S	ADDRE	SS (No	Street)				
609 Willow St.			Self Spouse 0	Child Other								
CITY		STATE	8. PATIENT STATUS		CITY						l ea	TATE
Anytown		WI			1						3'	AIE
ZIP CODE	TELEPHONE (Include		Single Married	d Other	770 0005			T				
	l		Employed F Full-Time	e Part-Time	ZIP CODE			TELE	PHON	IE (INCI	LUDE AREA	CODE)
55555	(XXX)XXX-		Student	Student						<u> </u>		_
OTHER INSURED'S NAME (LE	ast Name, First Name, M	liddle Initial)	10. IS PATIENT'S CONDIT	FION RELATED TO:	11. INSURED M-8	'S POLIC	Y GROU	P OR FE	CA N	UMBEF	7	
OTHER INSURED'S POLICY	OR GROUP NUMBER		a. EMPLOYMENT? (CURR	ENT OR PREVIOUS)	a. INSURED'S	DATE O	F BIRTH				SEX	
			YES	NO	MM.	1 DD	† YY		м	г—	F	
OTHER INSURED'S DATE OF	BIRTH SEX		b. AUTO ACCIDENT?	PLACE (State)	b. EMPLOYER	S'S NAME	OR SCI	HOOL N		<u> </u>		Ц
MM DD YY	I M	F	YES	NO I		. U INTINIE			WIE			•
EMPLOYER'S NAME OR SCH	OOL NAME		c. OTHER ACCIDENT?		- INCLUDATED	E Di 444	1010		D			
COTESTO NAME ON SON	IVIIIL			w	c. INSURANC	E PLAN N	NAME OF	n PHOG	HAM !	NAME		
INOLIDANOE EL TELEFO	DD0000444		YES	NO	ļ <u>.</u>							
INSURANCE PLAN NAME OR	PHOGHAM NAME		10d. RESERVED FOR LOC	AL USE	d. IS THERE	ANOTHER	RHEALT	H BENE	FIT PL	LAN?		
					YES		NO	<i>If yes</i> , re	eturn 1	to and c	complete iten	n 9 a-d.
READ PATIENT'S OR AUTHORIZE	BACK OF FORM BEFO	RE COMPLETING	3 & SIGNING THIS FORM.	13. INSURED	S OR AU	THORIZI	ED PERS	SON'S	SIGNA	ATURE I auti	norize	
to process this claim. I also red		payment o	f medical escribed b	benefits below.	to the un	dersig	ned ph	ysician or su	pplier for			
below.												
SIGNED			DATE		SIGNED							
DATE OF CURRENT: 4 IL	LNESS (First symptom)	OR 15.	IF PATIENT HAS HAD SAME	OR SIMILAR II I NESS		TIENT	NADI E 1	CO WOR	KING	· · · · · ·	NT COOLID	TION
				DD YY	16. DATES PA	DD	YY	U WUH	TO	MM	DD	YY
NAME OF REFERRING PHY		JBCF 17a	. I.D. NUMBER OF REFERRI	NG PHYSICIAN	18. HOSPITAL	IZATION	DATES	DELATE			ENT CERVIC	
			HEILER	NG TITOIOIAN	MM	DD	! YY	neun i		MM	DD Y	
. RESERVED FOR LOCAL US	=				FROM		<u> </u>		TC		<u> </u>	
. RESERVED FOR LOCAL US					20. OUTSIDE	LAB?		•	\$ CHA	RGES		
					1 —							
					YES		10					
. DIAGNOSIS OR NATURE OF	ILLNESS OR INJURY.	(RELATE ITEMS	1,2,3 OR 4 TO ITEM 24E BY	LINE)	YES 22. MEDICAID CODE			ORIGI	NAL R	EF. NO	.l	
	ILLNESS OR INJURY.		1,2,3 OR 4 TO ITEM 24E BY	LINE)	22. MEDICAID			ORIGI	NAL R	EF. NO	<u> </u>).	
	ILLNESS OR INJURY.			LINE)	22. MEDICAID	RESUB	MISSION	ORIGI	NAL R	EF. NO).	- 101
. <u>1365</u> . <u>9</u>	ILLNESS OR INJURY.	3		LINE)	22. MEDICAID CODE	RESUB	MISSION	ORIGI	NAL R	EF. NO).	
. <u>1365</u> . <u>9</u>	ILLNESS OR INJURY.	3	3	LINE)	22. MEDICAID CODE	RESUB	MISSION	ORIGI	NAL R	EF. NO).	
. <u>1365</u> . <u>9</u>	B Place T	3 C Type PROCEDUF	B. L D RES, SERVICES, OR SUPPL	E IES DIAGNOSIS	22. MEDICAID CODE 23. PRIOR AU	THORIZA	ATION NE	UMBER H EPSDT	1	J	K	
	B Place T of	3 C Type PROCEDUF	B. L D D D D D D D D D D D D D D D D D D	↓	22. MEDICAID CODE 23. PRIOR AU	THORIZA	ATION NE	UMBER H EPSDT	NAL R	J COB	К	
2. L A DATE(S) OF SERVICE	B Place T of	4 C Type PROCEDUR	B. L D.	E IES DIAGNOSIS	22. MEDICAID CODE 23. PRIOR AU F \$ CHARG	THORIZA	ATION NE	ORIGINAL DEPOSIT Family	1	J	K RESERV LOCAL	
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